Provider Advisory Group
Tuesday May 24, 2016
6:30pm – 8:00pm
Meeting Minutes

Attendees: Secretary Roberts, Steve Detoy, Jennifer Bowdoin, Diana Beaton, Sam Marullo, Alan Post, Clive Bridgham, Steve Brown, Dieter Pohl, Mary Dwyer, Peter Hollman, Donald Murphy, Director Alexander-Scott, Megan Ramney

I. **Welcome - Secretary Roberts**

Secretary Roberts: We have an assortment of items to talk about today, and I would like to start giving you all a briefing on the ICI, a new initiative doing out of EOHHS for the duals, some of the sickest in the state can be helped by this. I asked Jenn Bowdoin and Diana Beaton to come and give a brief description of what we are doing, as it is a fairly significant project with expected 10-14K may enroll.

II. **The Integrated Care Initiative – Phase II of the Federal Demonstration**

Jennifer Bowdoin: The ICI is an initiative started by EOHHS several years ago, actually a 2 phased initiative. The first phase has been underway for a while, which is less relevant today, but created the NHP Unity, RHO for those receiving LTC. Now in phase 2 creating a MME plan. A new plan scheduled to launch, sending letters within the next week to the first group, we are basically taking all the Medicare benefits people quality for (AB & D) and combining into a managed care product with their Medicaid benefits. Instead of having to managed two different benefits packages, different provider networks, it will all be combined into a new product called NHP Integrity. Paperwork from EOHHS may reference MM Plan, and that name is synonymous. All Medicaid benefits including LTC services (with a few carve outs, dental, transportation) all will be through the health plan. One integrated benefit for the people eligible for the program. On the benefits, they depend a bit on whether someone is in eh community, whether someone is in an intuitional setting, but in general some of the benefits are the simplification of the program, less complicated, and from a provider perspective less of a 'who's paying for what'. No co-pays for office visits, no co pays for prescription drugs, no additional plan premiums, no cost sharing for those enrolled in the program unless receiving LTC services in which they may have a cost of care associated with heir stay in a NH for example. NHP has some flexibility, so they can do things that we cannot always do in FFS programs; example they can waive prior authorizations, they can waive some requirements, copays are waived in this program for prescription drugs. NHP can also offer preventive services, even if someone doesn't qualify for LTC/Respite, they can put them in to avoid hospitalization or NH stay. NHP also has to provide robust care management services; we expect them to work with providers and provide additional wrap around to what is needed (more services to augment those that may already be in a practice if one exists). The goal is right size the care management to one individual. Are there questions?

Mary Dwyer: Is there such a thing as spend down?

Jennifer Bowdoin: Spend down is a part of Medicaid eligibility – this happens after someone qualifies for eligibility so this program doesn't really interact with that. If people are not receiving LTC services and they are in a spend down, we will not enroll them in this program as they can cycle on and off, and we wouldn't want to disrupt their services. For that population they will not be effected/eligible for this program. It is not a large percentage of the total dual eligible population in the state.

David Kroessler: Providers are credentialed with NHP already are automatically credentialed into this?
Jennifer Bowdoin: You should have received a contract amendment from NHP, so def. reach out to them if not. We require the managed care plans in the state not cherry pick, so if you have a contract with NHP you should have a contract amendment that includes this line of business, and you should have gotten rate information as well.

Mary Dwyer: On the behavioral health end of it, I know on Medicare they require some credentialing that is tighter. Does Medicare trump or?
Jennifer Bowdoin: We are trying to take the best of both worlds. If a provider could be credentialed in other ways with Medicaid they can be credentialed through this program, it is what the provider can do is within their contract with NHP.

Secretary Roberts: One of the things that is most valuable where sit is transitions of care. If you leave your home on LTC and you go into a hospital you go Medicare to Medicaid, and then can cycle again, so one of the things that NHP will offer is support and assistance to minimize the need for transitions, minimize incentives for incorrect support service locations.
Jennifer Bowdoin: NHP can take steps to incentivize care at the truly best place for the patients. I know we have a limited amount of time but I can tell you what to expect these next few months. We are doing a very slow enrollment process for this program, we are not just dumping all eligible into the program right away. We are doing a nine month enrollment process, to help reduce confusion. This program is entirely voluntary. Hal of those eligible will get an opt-in notice. This is the first group we will reach out to – stating if you are interested all this number or complete this application and we can enroll you. Three months of this opt- in group. You may see people coming in with a notice stating there is an MMP available – that requires an active step to enroll (numbers on their sheets and on the fact sheets being passed along). After three months we begin an enrollment for those who are to be passively enrolled. Anyone already in NHP and does not have a Medicare advantage plan can be auto enrolled. They will start to get letters in July – and their liters will indicate that they will be auto enrolled unless they call us by a certain date. If they get enrolled and then decide to disenroll they can do that at any time. They will get two notices for that group; notices end of the summer and then mid to late fall. We will continue that process until early 2017 as people become eligible we will continue to offer enrollment opportunities. This program sis scheduled to continue through 2020.

Steve DeToy: We did talk about putting together a mechanism for supporting office staff for when folks show up with their new cards.
Diana Beaton: Yes that is on my list.

Jennifer Bowdoin: If you feel you have additional questions, or want us to come out and speak to your groups to learn more we are happy to come out and do so. We have a dedicated email address for this program, and the contact info is also at the website, and we need to think a bit about the best way to provide strong information for support staff, trying to be thoughtful.

Peter Hollman: Are the institutional members going to be enrolled in this as well?
Jennifer Bowdoin: Yes, if they are Medicare and Medicaid eligible then they are eligible for this program generally speaking (ESH is an exception), and an age cut off of no younger than 21. If someone in PACE wants to be in this program we would honor it but they would need to disenroll from PACE to enroll in this. We are not doing specific outreach to that group.

Peter Hollman: Basically we received a notice indicating that providers would get about the same rate, so if MMP then the Medicare allowance. Is it all being run out of NHP of RI?
Jennifer Bowdoin: NHP may have referenced something in that letter that is specific to the plan. We will have a call center that is initially out of state, in Illinois, and then we will bring it into RI as a part of the HSRI contact center in about six months. Beyond that this is in state, NHP is the vendor. They are planning to revisit some rates in the future so as to incentivize more cost effective care.

Peter Hollman: Will people be on one prescription drug plan or multiple?
Jennifer Bowdoin: They will be on NHP's plan, and they will have a formulary up soon, prior to going live. NHP has been doing a lot of provider training, so if it is helpful to have them come talk to office staff we can help facilitate that. They have dedicated numbers, and so we do want to work with NHP as some things for this program the state is running like the call center, like the ombudsman program, but that sheet for staff would also be key for NHP to share their key numbers as well. We are doing this trickle in approach as per example from other states.
Steve Brown: So what about providers who accept Medicare but not NHP?
Jennifer Bowdoin: Yes there are exceptions. If someone sees a provider who is not in NHP, NHP has to allow the person to see the provider for a continuity of care period, usually about six months. Also a continuity of care period, though different, for prescription drugs. NHP then has to make an effort to contract out to the provider in question. If the provider does not want to be in NHP, but does want to see the individual, NHP can do a single case agreement – that may happen with specialists for example.

Steve Brown: I know there is no oral surgeon in the state who accepts NHP, but many accept Medicare.
Peter Hollman: There may be people who take Medicare only.
Jennifer Bowdoin: There are certain specialties that are more problematic than others. NHP's network was validated by CMS to meet federal requirements – around providers by county by type and the network has been validated to meet that.

III. **Governor's Opioid Task Force – Strategic Plan: The Provider Role – Director Nicole Alexander-Scott**

Director Alexander-Scott: We are saving paper and will refer you to the presentation up on the screen. Slides available upon request via email to lauren.lapolla@ohhs.ri.gov.

Steve DeToy: On enrollment that is 80% of controlled sub registration? [Yes] what is the methodology for coming up with utilization – I struggle with how we come up with 40% 60% utilizing…
Director Alexander-Scott: I can get you the actual definition in terms of whether there is actual frequency with what we are qualifying as utilization, but we can assess…
Steve DeToy: You are supposed to utilize every time you starts and prescription, but is there an algorithm to say this prescription has never been with this patient before?
Director Alexander-Scott: It is more how often someone is checking reports and accessing; we do have # of prescription given and # of times scripts are checking in the PDMP. It is an accurate point to say our utilization is an underestimate of what current regs require.

Megan Ramney: My residents, the vast majority are not in PDMP. Likely because the controlled substance is hospital wide. Working in a teaching institution that is a huge issue. Also regarding EHR integration – there are some programs out there that do push notifications for ERs. There is an EDIE that looks at things like PMDP does analytic work – could pull cross border, does a push notification in the EMR, and in the emergency room that is really helpful. It is very helpful – we talked to the Secretary about it a bit a few weeks ago, and it is very different from what CurrentCare offers so separately beneficial and helps with that acute pain issue. Can alert us to people who are particularly high risk and we can refer them to saboxone providers or recovery coaches.
Steve DeToy: And there is a bill looking at that EMR single sign on.

Megan Ramney: Looking at it for us, in the emergency room that separate sign in is a huge work flow barrier. Even if it's in the EMR, with the push notification it can be multi useful.
Director Alexander-Scott: You are spot on, that is the goal. The leg to be passed is key, and then the Mass Director of health and I are talking this week to ask about it further.

Steve Brown: Why need legislation?
Steve DeToy: There are some vendors who are resistant or want to charge money for resistant; others thing a belt and suspenders is helpful.

Dieter Pohl: These limits are for first prescription only right?
Director Alexander-Scott: Yes.
Peter Hollman: And an issue of asking what 30 MME is may be tough to answer off hand.
Director Alexander-Scott: Right we are working to communicate that out, and communicate a standard calculator for determining it. We are working with the plans to help us implement these limits that is the benefit that we have for support.

Dieter Pohl: So I give patient prescription, they go to pharmacy… how does it work?
Director Alexander-Scott: If it is more than 60 days we are saying it is an initial prescription. We are setting it up tithe Pharma benefit programs in that it could be rejected in terms of being

covered, or it could be supported for prior authorizations for extensions.
Peter Hollman: That will never work at the prescription point. You can have patients in the ICU getting antibiotics, and they wouldn't get it at the pharmacy. So would it be that they won't cover it, or is it that I can only give you ten?

Peter Hollman: The bill pending is a cut off, so only a few. The idea of prior authorizations at the point of care won't work. For one, the pharmacist won't do anything for you, or say the prescription is no good and don't notify the office. It is a difference between is the prescription ok, is it totally disqualified, is it OK to the limit of 30 MME times 20, I want all those things to be looked at.
Dieter Pohl: I just want to be sure a patient doesn't have to stand there if they really need it. Also for those weight loss surgery, we would write prescriptions before the surgery and have a family member pick it up, as often it can take so long to get prescription in when the patients need it. Because if they don't have it they will go to the ER. You cannot expect that all physicians will be totally correct from day one. We just want to think it through.
Director Alexander-Scott: Want to keep it focused on acute pain, not related to some of the major surgeries where you need a longer term prescription. Then for the provider also using their judgement based on the client. We are continuing to fine tune and work through some of this feedback. The leg is also going through in a different way, which may over ride what we go through w the plans. There are still elements we are working through – want the focus to be on acute pain, initial prescriptions, and similar to other similar states, there is a need to figure out the enforcement piece. We want to do it in a way that makes sense from the insurers stand point, and be ready if leg comes through that trumps or accelerates what that process looks through.

IV. **Alternative Pain Management Options – A word from our Chiropractors**

Dr. Clive Bridgham & Dr. Alan Post [slides available upon request via email to lauren.lapolla@ohhs.ri.gov]

Dieter Pohl: Your goal is to get chiropractic into community health centers?
Alan Post: My goal is to end the discrimination against the profession. There are other programs, hospitals n the US where chiropractors are on call – I would like to see it fully integrated into the system. One of the contributing factors to elevating chiropractic in the system as well as pharma, there are barriers here to seeing a chiro. I may see a client for 2 or 3 visits for one issue, then another issue arises, that I could treat them for, yet their number of.
Clive Bridgham: Our overall focus is the integration of having access of Rhode Islanders to chiro services in many models and explore the opportunities to help with care delivery in RI.

Dieter Pohl: What going forward what is the state's stance on other alts, like acupuncture, and massage therapy?
Alan Post: Right and chiropractic is probably used the least.
Secretary Roberts: Under Medicaid you have to apply to the federal government to cover items that are not traditionally covered. To expand we would need to get permission from the feds

specifically.

Dieter Pohl: Talking about pain, when I left Germany 20 years ago we learned about acupuncture. It is out there, just not the American way, I think it is a great way to expand and save money.
Clive Bridgham: Unfortunately too we are not integrated into the EMRs, so unless I generate a report based on a referral, we are otherwise outside the bubble there. And through Laura Adams in my practice I am working towards the meaningful use paradigm to try to integrate what I do into the Medicare program and start to do analytics on what we are doing.

Steve Brown: How many chiropractors in RI?
Clive Bridgham: 90-100 practicing.
Steve Brown: Is that a good number, a bad number, trouble recruiting to RI?
Alan Post: I know it's a challenge recruiting – similar issue for specialties in reimbursement rates are low Vis a Vis cost of living.

V. **Legislation on Opioid Prescriptions**
Secretary Roberts: I am going suggest that we move this item to next month given the time and include it to discuss bill that passed by the next time we meet that impact providers.
Steve DeToy: If I may, there is a piece of legislation that has been introduced at the request of the AG that would allow the AG to have unfettered access to the PDMP. If you all could make a call tomorrow to your house rep that would be very helpful; I believe it passed the senate tonight - please reach out to your reps. RIMS feels it is a very bad bill, so reach out an communicate about this. We want a strong balancing act between proper treatment and not over reaching – and we don't want to tamper the ability to treat or be treated. I will remind everyone our next meeting is in June.

VI. Public Comment – Public Comment session was offered but no comments were put forward at this time.

VII. Adjourn